SECTION II:

OVERVIEW OF OPERATING DIVISIONS (OPDIVs)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

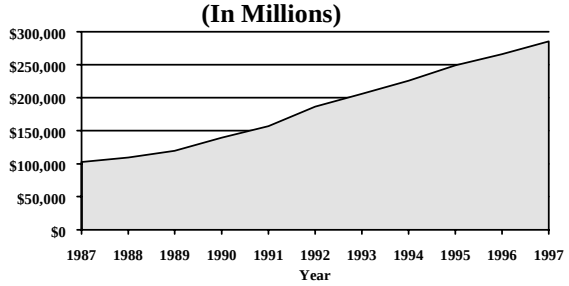
HCFA is responsible for administering Medicare, Medicaid, and beginning in 1998, the Children's Health Insurance Program. HCFA is the largest purchaser of health care in the world.

HCFA has approximately 4,000 employees, about 1,380 of who work in ten regional offices around the country providing direct services to Medicare contractors, State agencies, service providers, beneficiaries and the general public. Approximately 2,620 employees work in Baltimore and Washington, D.C. providing funds to Medicare contractors, writing policies and regulations, developing more efficient operating systems, setting payment rates, managing programs to fight fraud, waste, and abuse, monitoring contractor performance, and assisting States and Territories with Medicaid issues.

Many of HCFA's important operational activities are carried out through third parties: (1) 22,000 employees at 65 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and responding to queries from beneficiaries; (2) 34,000 State employees have primary responsibility for administering Medicaid; (3) 6,000 employees in 53 State survey agencies have responsibility for inspecting hospitals and nursing homes and other facilities to ensure that health and safety standards are met; and (4) 1,600 employees at 53 Peer Review Organizations conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

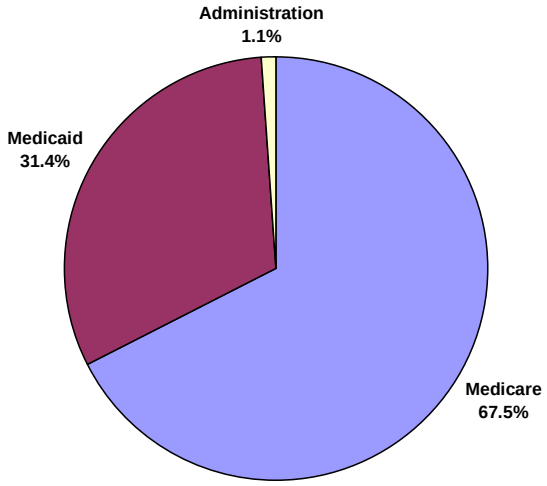
The number of Medicare enrollees and Medicaid beneficiaries has been continually increasing, along with the general rises in the costs of high technology, the incidence of chronic illnesses, and the costs of health care goods and services. These factors are reflected in the significant increases in budgetary outlays as can be seen from the accompanying trendline. HCFA had $285.5 billion in net outlays in FY 1997, a 178% increase over the $102.6 billion in FY 1987.

Health Care Financing Administration
Net Outlays
(In Millions)



HCFA is by far the largest budget component of HHS, accounting for 85 percent of HHS total net outlays, and almost 84 percent of HHS expenses in FY 1997.

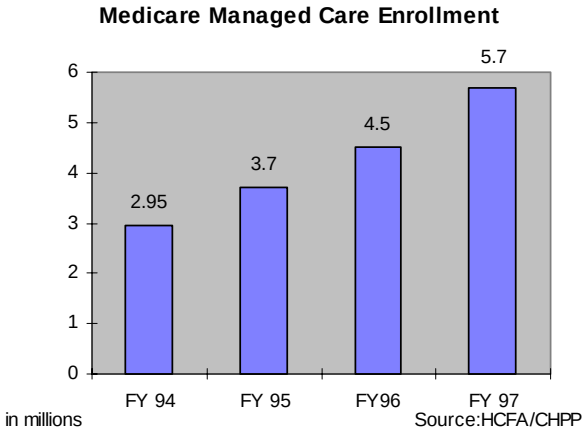
HCFA FY 1997 Expenses



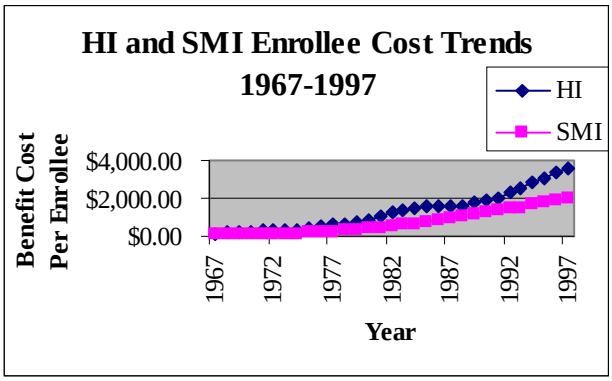
Nursing homes participating in Medicaid provide care to many older Americans.

MEDICARE

Medicare is a combination of two programs, Hospital Insurance (HI) and Supplementary Medical Insurance (SMI), each with its own enrollment, coverage and financing. BBA created a third program called Medicare+Choice that restructures the Medicare managed care program and, through user fees, provides funding for better consumer information. Since 1967, Medicare enrollment has increased from 19.5 million to 38.6 million beneficiaries, a 98 percent increase in twenty years. Recent years have also seen significant increases in managed care enrollment in the Medicare program, as illustrated in the accompanying chart.



Note: See Sections III and VI for discussion on audit findings, including the claims error rate on the Medicare fee-for-service program.



Medicare Part A – Hospital Insurance (HI) Program

HI is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security or Railroad Retirement benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays participating hospitals, skilled nursing facilities, home health agencies, and hospice providers for covered services rendered to HI enrollees.

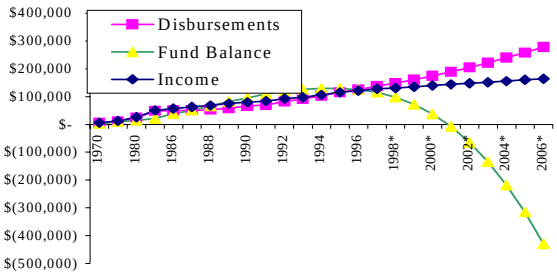
Part A is financed through the HI Trust Fund, whose revenues come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). In 1997, the Medicare HI payroll tax rate was 2.9 percent of payroll, split evenly between employees and employers, with no limitation. The self-employed paid the full 2.9 percent. Collections from today's workforce are deposited into the HI Trust Fund, and disbursements from the Trust Fund pay expenses for today's beneficiaries. The accumulated Trust Fund assets (from the years prior to 1995 when collections exceeded disbursements) are invested in interest earning U.S. Treasury Securities. Since calendar year 1995, annual disbursements have exceeded annual collections, and the HI Trust Fund asset balances are declining as those securities are redeemed. (Interest revenue on investments is recognized by the Trust Fund as it is earned.) Unlike the assets of private pension plans, trust funds do not consist of real economic assets that can be drawn down in the future to fund benefits. Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. (When financed by borrowing, the effect is to defer today's costs to even later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, does not make it easier for the Government to pay benefits. Reflecting both the law and existing Federal

accounting standards, no liability is recorded for benefits which may be paid in the future on behalf of today's workers who are currently paying taxes into the Trust Fund and who expect to be future beneficiaries upon their retirement.

Demographic trends pose a long-term challenge to the sustainability of the HI Trust Fund. In 1967 there were 19 million enrollees in HI, compared to 38.6 million in 1997. The retirement of the baby boom generation will be financed by a relatively smaller number of persons born after the baby boom. For example, in 1996 there were 38 million beneficiaries with 147 million workers to support them. In 2030 as the last baby boomer turns 65, there will be an estimated 76 million beneficiaries with 173 million workers to support them. This means that every beneficiary in 1996 had 3.9 workers to pay for their HI benefits, but in 2030 there would be only about 2.3 workers. The ratio is expected to continue to decline until there are only 2 workers per beneficiary by 2060. (It is interesting to note that in 1966, the year the Medicare program began, there were 4.5 workers for every beneficiary.) Therefore, HI expenditures are projected to grow rapidly as a fraction of workers earnings, from 3.5 percent in 1996 to about 11.5 percent in 2070. Average costs incurred per HI enrollee have mushroomed from $152 in 1967 to $3,944 in 1997.

BBA legislated modifications to the Medicare programs, including some which extended the solvency of the HI Trust Fund for more than a decade. Before that legislation, the Trust Fund insolvency date was expected to occur in 2001.

Operations of the HI Trust Fund During Fiscal Years 1970-2006 (Dollars in Millions)



***Intermediate Estimates made prior to BBA'97, which extended solvency. Source: HI 1997 Trustees Report, Table II.D.1.**

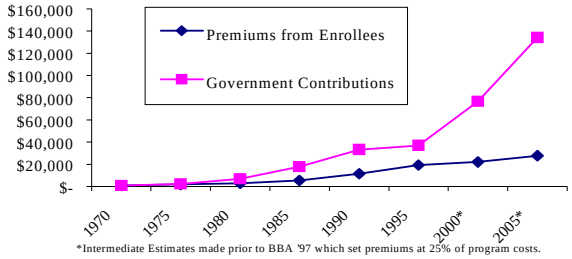
Medicare Part B – Supplementary Medical Insurance (SMI)

SMI is available to nearly all people aged 65 and over and disabled people. SMI covers physician and outpatient care, laboratory tests, home health care, durable medical equipment, designated therapy services and other services not covered by HI. SMI coverage is optional and subject to monthly premium payments by the beneficiaries (many of who pay via a direct deduction from their Social Security checks). About 95 percent of HI enrollees elect to enroll in SMI. The premiums paid cover only about one quarter of the program's costs; SMI is financed primarily by general fund appropriations (taxes paid by the general public), which match enrollee's premium payments on an approximate three to one basis. Beginning in January 1997, the monthly SMI premium was $43.80 ($525.60 per year – compared to an annual SMI per enrollee cost of $2,034).

SMI enrollment continues to grow, along with growth in average costs per enrollee. In 1967, there were 17.7 million SMI enrollees costing an average of $62 for covered services. In 1997, there were 36.2 million enrollees costing an average of $2,234 for those receiving services.

BBA legislated that SMI premiums will cover 25 percent of program costs each year, with the rest to be provided by general appropriations. Before that legislation was enacted, Trustees had cautioned that premiums would cover a declining portion of program costs.

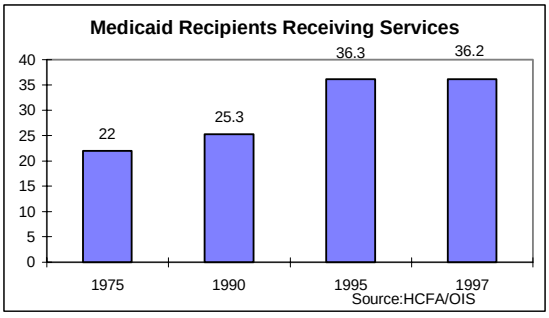
SMI Revenue:
Premiums Paid by Enrollees
vs.
Government Contributions Paid by General Public

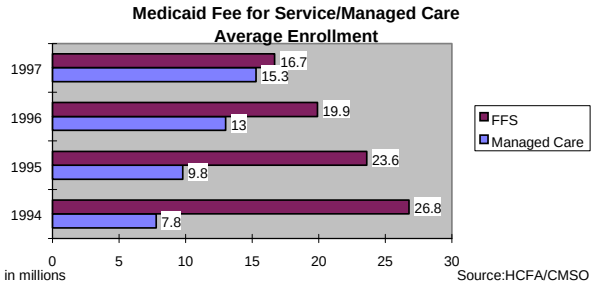


*Intermediate Estimates made prior to BBA '97 which set premiums at 25% of program costs.
Source: 1997 SMI Trustee Report, Table II.D.1.

MEDICAID

Medicaid is the means-tested health care program for low income Americans, administered by HCFA in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, however, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid enrollees receiving services has increased from 10 million beneficiaries in 1967 to 36.2 million in 1997, an increase of 262 percent. Approximately six million people are dually entitled, that is, covered by both Medicare and Medicaid. *Medicaid recipients are now 13.4 percent of the total civilian population.*





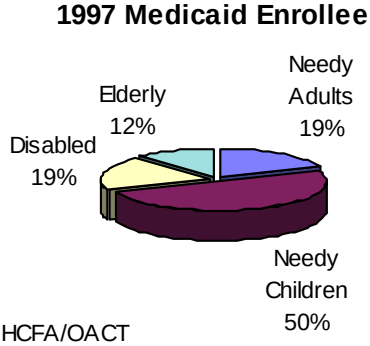
Under Medicaid's division of responsibilities, HCFA provides matching payment grants to States and Territories.

- State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1997, the Federal matching rate among the States ranged from 50 to 77 percent, with a national average of 57 percent.

- Federal matching rates for various State and local administrative costs are set by statute, and in 1997 averaged 56 percent.

Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act fund Medicaid grants. There is no cap on Federal matching payments to States. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States. For example, 27 State Medicaid programs cover psychological services, 49 cover adult dental services, and seven cover services of medical social workers.

An estimated 36.2 million Medicaid enrollees receive services. Children comprise 50 percent of Medicaid enrollees receiving services, but account for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 31 percent of Medicaid enrollees receiving services but accounted for 64 percent of program spending. The elderly and disabled use more services in all categories, particularly nursing home services.



Medicare Trust Fund Solvency

Prior to the enactment of the Balanced Budget Act (BBA) of 1997, the Boards of Trustees for the Hospital Insurance (HI - Medicare Part A) Trust Fund and Supplementary Medical Insurance (SMI - Medicare Part B) Trust Fund issued the 1997 Annual Reports on the Trust Funds. BBA made certain legislative modifications to the Medicare programs, including extending the solvency of the HI Trust Fund for more than a decade, and setting the SMI premium rate at 25% of program costs. *The statistics provided here do not incorporate the recent changes by BBA.*

Highlights from the 1997 HI Trustee Report:

- HI covered 33 million aged and 5 million disabled beneficiaries. The total number of HI beneficiaries increased by 1.4 percent in 1996, and by 22.4 percent over the last 10 years.
- HI benefits amounted to $128.6 billion in 1996, a 10 percent increase over 1995. Average expenditures per HI enrollee increased by 9 percent to $3,400.
- HI program expenditures exceeded annual income in calendar year 1996. Under intermediate assumptions, the HI Trust Fund was estimated to be depleted in 2001.
- There are expected to be 3.6 workers per HI beneficiary when the baby boom generation begins to reach age 65 in 2010. Then, the worker/beneficiary ratio is expected to rapidly decline to 2.3 in 2030 as the last of the baby boomers reaches age 65. The ratio is expected to continue declining thereafter (but more gradually) as life expectancy continues to lengthen, reaching 1.98 in 2070. This ratio is important because the bulk of HI revenues come from payroll taxes. When the Medicare program was established in 1966, the ratio was 4.47.
- HI expenditures are projected to grow rapidly as a fraction of workers' earnings, from 3.5 percent in 1996 to about 11.5 percent in 2070. As a fraction of the Gross Domestic Product (GDP), expenditures would grow somewhat more slowly, from 1.7 percent in 1996 to about 5 percent in 2070.
- Projected HI tax income would meet only a declining share of expenditures under laws existing as of the spring of 1997. Tax income is expected to equal 84 percent of expenditures in 1997 and 74 percent in 2001 (when the fund was estimated to be depleted), and would cover less than one-third of costs 75 years from now.

Highlights from the 1997 SMI Trustee Report:

- SMI covered about 32 million aged and 4 million disabled persons who chose to enroll in the program. The total number of SMI enrollees increased by 1.3 percent in 1996, and by 18.4 percent over the past 10 years.
- SMI benefits have been growing rapidly. Outlays have increased 45 percent over the past 5 years (33 percent on a per-beneficiary basis). During this period the program grew about 14 percent faster than the economy as a whole, despite efforts to control SMI costs.
- SMI expenditures are expected to continue to grow faster than the economy as a whole. SMI outlays were almost 1 percent of Gross Domestic Product (GDP) in 1996 and are projected to grow to about 2.5 percent by 2020.

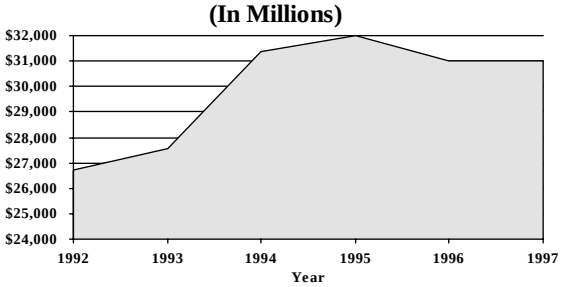
Source: 1997 HI and SMI Trustees Reports and HCFA Office of the Actuary. Note: *1998 trustee reports will be issued in spring 1998, incorporating the impacts of BBA.*

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

ACF is responsible for almost 50 Federal programs which address the needs of vulnerable individuals throughout the country, including Native Americans, individuals with developmental disabilities, refugees and legalized aliens. ACF's programs are diverse and wide-ranging: from Head Start to Low Income Home Energy Assistance, from Foster Care and Adoption Assistance to Child Support Enforcement and Temporary Assistance to Needy Families (TANF), from Runaway Youth to Family Support and Preservation. In addition to programs focused on specific population groups, ACF oversees block grants which fund a range of social services for low income individuals across the country. Through these programs, ACF seeks to lead the nation in improving the economic and social well-being of families, children, individuals and communities.

ACF received $37.6 billion in FY 1997 appropriations, which included both direct appropriations and amounts preappropriated for FY 1997 as part of welfare reform. This represents an increase of $4.3 billion over the level of FY 1996 appropriations due largely to discretionary increases for Head Start and entitlement increases for programs involved in welfare reform. Net outlays were $31.02 billion in FY 1997, well below the FY 1995 level of $32 billion. FY 1997 costs include the transition to, and start-up period for the new welfare reform programs.

Administration for Children & Families
Net Outlays
(In Millions)



ACF's mission is reflected in the strategic goals that it submitted in FY 1997 for its FY 1999 Annual Performance Plan:

- Improve the economic independence and productivity of families,
- Increase the health, development, safety and well-being of children and youth,
- Deliver high quality services to help develop healthy, safe and supportive communities and tribes, and,
- Be a high performing, customer-focused, results-oriented organization.

For a number of years, ACF has been a principal player in working to overhaul the nation's welfare system. This effort culminated with enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. ACF is responsible for the implementation and management at the Federal level of this new legislation including responsibility for administering the TANF and the enhanced Child Support Enforcement programs.

Both parents share responsibility for the children they bring into the world.

ACF's New Temporary Assistance for Needy Families (TANF) Program: How it Works

On August 22, 1996, President Clinton signed into law The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, a comprehensive, bipartisan welfare reform plan that dramatically changes the nation's welfare system into one that requires work in exchange for time-limited assistance. The Temporary Assistance for Needy Families (TANF) program replaces the former AFDC and JOBS programs. Under TANF, States, territories and tribes operate programs. States, territories and tribes each receive a block grant allocation; States and territories have a maintenance of effort requirement. The basic Federal block grant is $16.5 billion annually through fiscal year 2002. The block grant covers benefits, administrative expenses and services. States, territories and tribes determine eligibility and benefit levels and services provided to needy families, and there is no longer a Federal entitlement.

Under TANF, an initial assessment of recipients' skills is required. With few exceptions, recipients must work after two years on assistance. Twenty-five percent of all families in each State or territory must be engaged in work activities in FY 1997, increasing to 50 percent in FY 2002. Single parents must participate for at least 20 hours per week in 1997, increasing to at least 30 hours per week by FY 2000. Two-parent families must work 35 hours per week.

To count towards State work requirements, recipients are required to participate in unsubsidized or subsidized employment, on-the-job training, work experience, or community service; they may also attend 12 months of vocational training, education directly related to employment, attend secondary school, or get a GED if they have not completed secondary school or received such a certificate, or provide child care services to individuals who are participating in community service. Up to six weeks of job search (no more than four consecutive weeks) can count towards the work requirement. Single parents with a child under six who cannot find child care cannot be penalized for failure to meet the work requirements. Families with an adult who has received Federal assistance for five cumulative years (or less at State option) will be ineligible for further Federal assistance under the new welfare law.

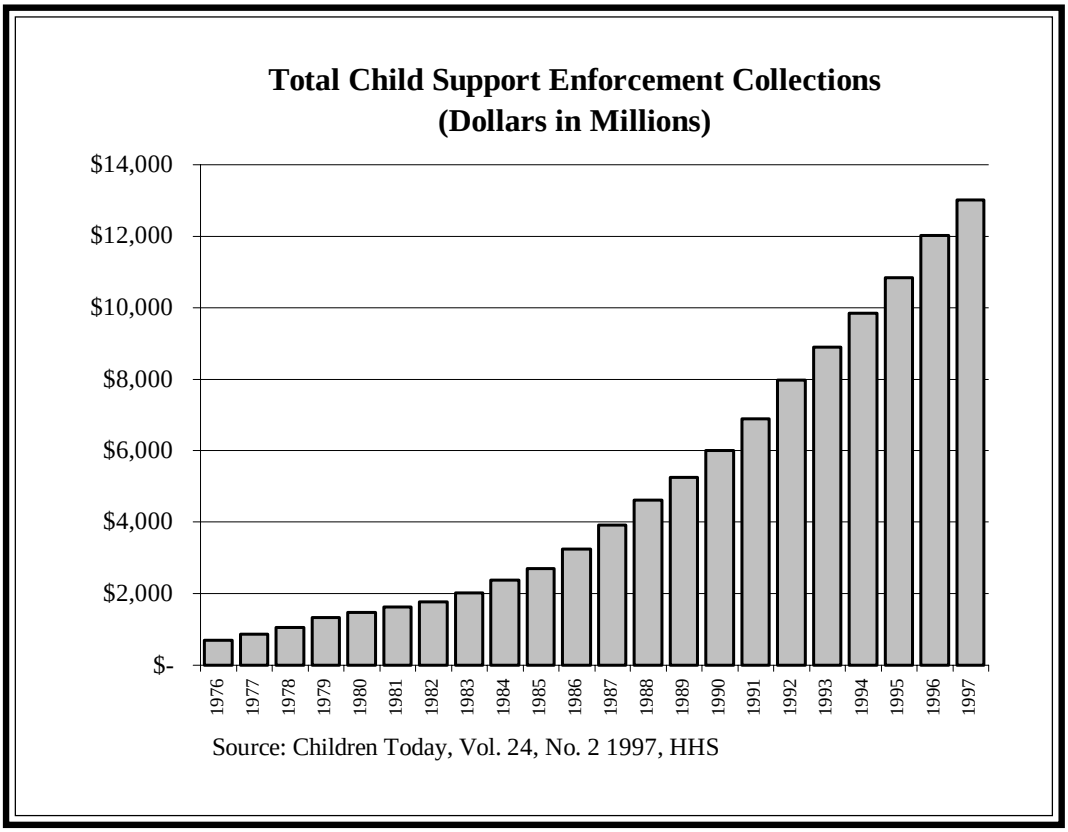
Just as the welfare reform legislation has given the States new tools to attack the problem of welfare dependency, it has also given them tougher measures to attack the problem of unpaid child support. HHS announced a record $13 billion in child support collections for 1997, which brought to 50 percent the aggregate increase in collections over the last five years. In addition, HHS announced that paternities established and acknowledged almost doubled to over1 million cases in 1992. (See Table below)

"...(I)t's clear to everyone that in recent decades too many parents, especially men, have not taken their responsibilities seriously enough to their families, their children, and themselves. And there are serious consequences. We know, for example, that the simple failure to pay child support is one of the chief reasons women and children are on welfare."

President Bill Clinton
October 4, 1997 Radio Address

GPRA Pilot Program Measure	1994	1995	1996	1997*
Total paternities established and acknowledged.	676,459	930,833	1,041,679	1,002,801
Total child support collections.	$9.8 billion	$10.8 billion	$12 billion	$13 billion

* Data for FY 1997 is preliminary.



Other ACF programs of note include Head Start, Foster Care and Adoption Assistance.

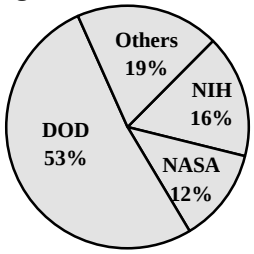
- Head Start is a national program which provides comprehensive developmental services for America's low-income, pre-school children ages three to five and social services for their families. In 1994, the program was expanded to include low-income pregnant women and families with infants and toddlers. Approximately 1,400 community-based non-profit organizations and school systems and other public agencies develop unique and innovative programs to meet specific needs. Grants to conduct Head Start programs are awarded to local public or private, non-profit agencies. At least 10 percent of the enrollment opportunities in each program must be made available to children with disabilities. In FY 1997, the enrollment of 793,809 pre-school children from low-income families was made possible by grants amounting to $3.981 billion. Since its inception in 1965, more than 16.9 million children and families have received services.

- Foster Care and Adoption Assistance programs provide Federal matching funds to States which directly administer the programs. These programs are funded jointly by the Federal and State governments. Monthly payments to families and institutions vary from State to State. Children in foster care numbered more than 500,000 in 1996, up from 340,000 in 1988. Most of these children will return to their homes, but more than 100,000 cannot return safely. Many of these children are considered to have "special needs" because they are older, members of minority or sibling groups, or physically, mentally or emotionally disabled. They often need special assistance in finding adoptive homes. Currently, over 100,000 children receive adoption assistance, in the form of an ongoing subsidy to families who adopt special needs children. In FY 1997, approximately $3.8 billion was available for Foster Care, $595 million for Adoption Assistance, and $70 million for programs to help children move from Foster Care to Independent Living.

THE NATIONAL INSTITUTES OF HEALTH (NIH)

The mission of NIH is to sponsor and conduct research that leads to better health for all Americans. The NIH is actually a federation of 22 Institutes, Centers, and Divisions (ICDs), each charged with a unique mission. A mission may focus on a given disease, such as cancer, mental illness, or infectious diseases; on a particular organ such as heart, kidney, or eye; or on a state of development, such as childhood or old age. In other instances, a mission might encompass crosscutting needs and opportunities, such as the development of research resources or the sequencing of the human genome. (In addition to the 22 ICDs, the NIH has numerous other activities funded by its building and facilities appropriation, revolving and trust fund accounts.) The results of NIH research benefit all Americans and contribute to improvements in worldwide health status. From before birth to the end stages of life, each one of us has or will be touched, directly or indirectly, by medical research.

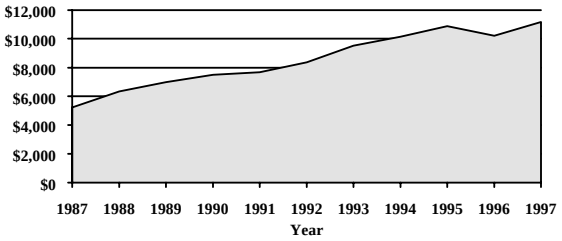
Federal FY 1997 Outlays for Conducting Research and Development



Source: President's FY 1998 Budget. Figures are FY 1997 estimates.

NIH received $7,257 million in research funding in FY 1997, representing 16.3% of the entire Federal research budget. Only the Department of Defense conducts more research than NIH.

National Institutes of Health Net Outlays (In Millions)



More than $8 out of every $10 (approximately 82%) appropriated to NIH flows out to the scientific community at large; of these funds, the lion's share supports individual scientists. This extramural system is premised on independence, embodied in investigator-initiated research; on self-governance, embodied in peer review of scientists; by scientists as the primary basis for judging the merits of research proposals; and on the powerful incentive of competition among the more than 50,000 investigators affiliated with some 2,000 university, hospital, and other research facilities located in all 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and points abroad. NIH provides training support to this community through a variety of mechanisms including 1) research training grants, 2) individual fellowships, and 3) career development awards.

Approximately 10 percent of the total NIH budget supports a core program of basic and clinical research administered and staffed by NIH's own physicians and scientists. Through this intramural research program, more than 9,000 researchers and technical support staff conduct basic and clinical research at on-campus research facilities in Bethesda, Maryland, and at off-campus locations in Baltimore, Maryland; Research Triangle Park, North Carolina; Hamilton, Montana; and Phoenix, Arizona. One of the unique features of the NIH intramural research program is the close proximity of many of its research laboratories to the Clinical Center, a research hospital on the NIH campus. Together, these facilities provide a location for bridging the gap between basic and clinical science. An additional and important byproduct of intramural research is the cadre of young physician-researchers and basic scientists who are trained in this unique program.

In addition to striving for scientific excellence, the NIH also seeks to be a model of administrative effectiveness, managing its appropriated funds to maximize the public benefits derived from NIH research. At the request of the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, the NIH undertook a comprehensive review of the agency's administrative structure and costs. The primary purpose of this examination was to document the effectiveness of current practices and identify areas for future improvements.

In considering the major recommendations that emerged from this review – in conjunction with ongoing efforts to enhance the effectiveness of NIH's administrative operations – the agency will focus on a number of high priority areas including: accounts payable; property management; personnel delegations; procurement; time and attendance system; and information technology management. In addition, the NIH will undertake, with user involvement, an overall assessment of security services. Among the other initiatives to be pursued, many will be aimed at better managing the decentralized delivery of administrative services; strengthening the partnership between the scientific and administrative staff; and establishing increased administrative accountability throughout the NIH.

NIH's Top Research Accomplishments and Findings in FY 1997

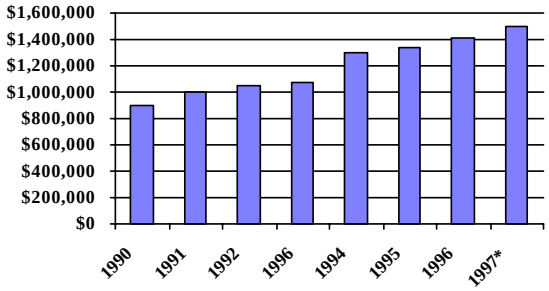
Laboratory Research:

- A programmed cell death mechanism underlies inherited Alzheimer's Disease.
- The same cause may underlie many neurodegenerative diseases, including Huntington's Disease.
- Retinoic acid, a derivative of Vitamin A, reverses emphysema in the lungs of laboratory rats.
- Discoveries were made related to the role that genes play in diseases such as prostate cancer, Stargardt's disease (an inherited childhood eye disorder), and Parkinson's Disease.

Clinical Trials:

- Vitamin E and the drug selegiline delayed loss of function in daily activities in Alzheimer's patients by about 7 months.
- Treatment with a low-dose diuretic to reduce high systolic blood pressure cuts strokes and heart attacks by a third in older patients with diabetes.
- Implantable cardiac defibrillators reduce deaths from arrhythmia.
- Anti-HIV drug cocktails restore partial immune function and can delay disease progression and death.

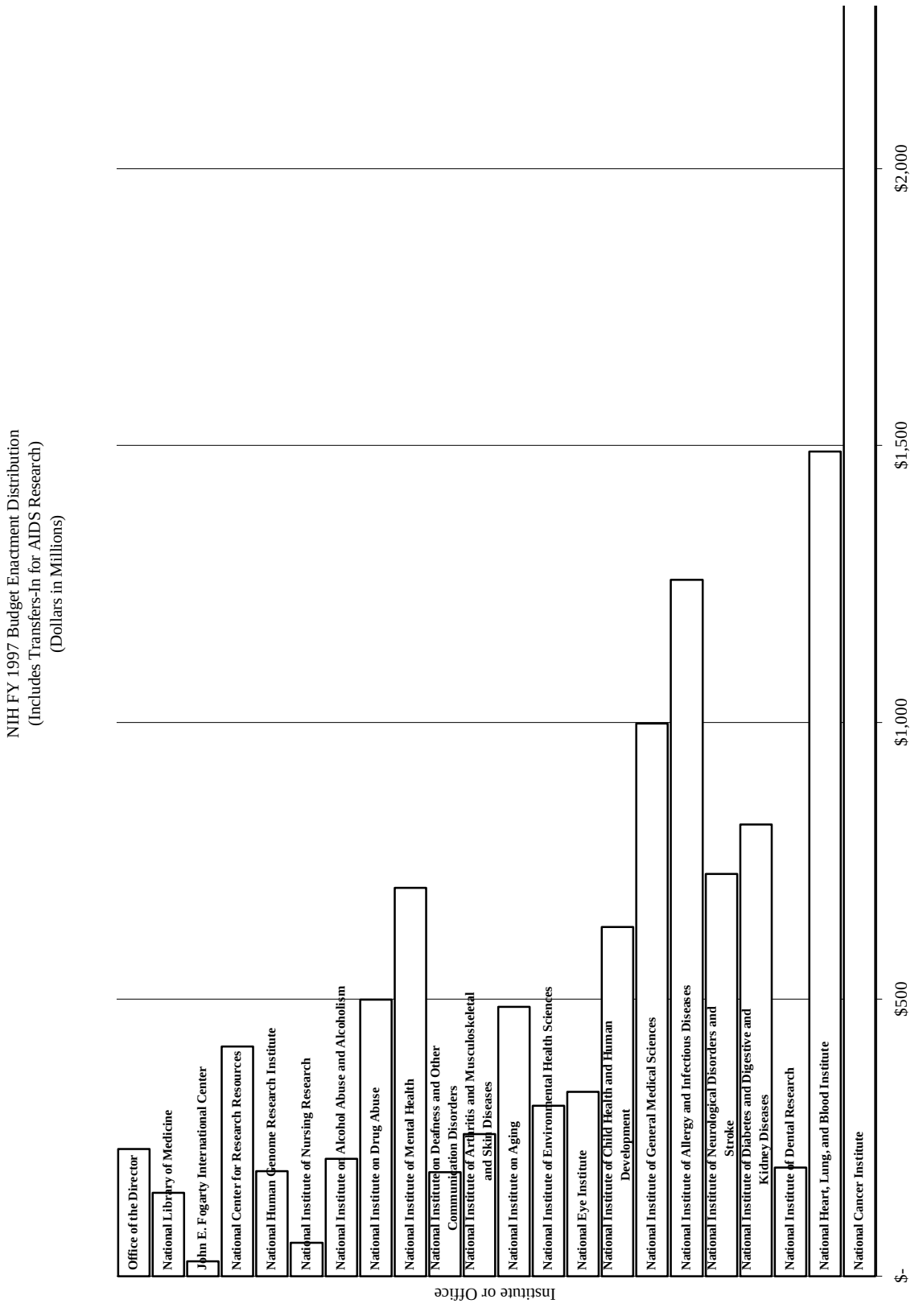
National Institutes of Health
HIV/AIDS Funding
(Dollars in Thousands)



***Enacted amount, not actual.**

Applied Research:

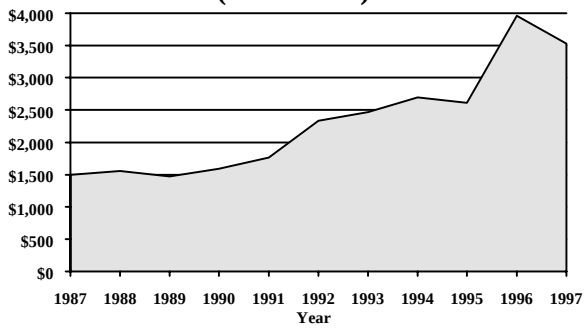
- Cockroach allergy and exposure are an important cause of asthma illness among inner-city children.
- Breast cancer gene alterations (occurring with relatively high frequency among Ashkenazi Jews) were associated with increased cancer risk.
- Novel plastic beads were developed as a means to enhance drug delivery.
- A new technology was developed for diagnosing chromosomal defects.
- NIH funded nearly 20 telemedicine projects to deliver medical services to sites that are at a distance from the provider.


NIH FY 1997 Budget Enactment Distribution
(Includes Transfers-In for AIDS Research)
(Dollars in Millions)
Office of the Director
National Library of Medicine
John E. Fogarty International Center
National Center for Research Resources
National Human Genome Research Institute
National Institute of Nursing Research
National Institute on Alcohol Abuse and Alcoholism
National Institute on Drug Abuse
National Institute of Mental Health
National Institute on Deafness and Other Communication Disorders
National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute on Aging
National Institute of Environmental Health Sciences
National Eye Institute
National Institute of Child Health and Human Development
National Institute of General Medical Sciences
National Institute of Allergy and Infectious Diseases
National Institute of Neurological Disorders and Stroke
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Dental Research
National Heart, Lung, and Blood Institute
National Cancer Institute
Institute or Office
$-
$500
$1,000
$1,500
$2,000
Budget Enactment Distribution
Source: NIH

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA administers a variety of health programs including those dealing with: health professionals education and training, primary care (Community Health Centers, National Health Service Corp., Black Lung Clinics, National Hansen's Disease Program Center), maternal and child health, HIV/AIDS, rural health (and telemedicine initiatives), vaccine injury compensation, the National Practitioner Data Bank, public health and preventive medicine programs, chiropractic demonstration projects, organ procurement and transplantation, and the National Bone Marrow Donor Registry.

Health Resources and Services Administration Net Outlays (In Millions)



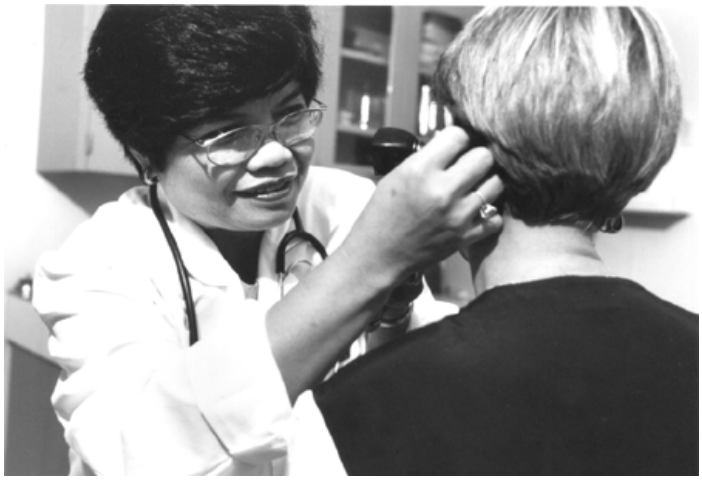
HRSA has a history of increasing net outlays, due in part to increased funding for the Ryan White AIDS CARE Act. FY 1996 had a spike in recorded net outlays due to the identification of outlays, which should have been attributed to prior years. (An analysis of budget authority would show a more level rate of increase over the same ten-year period.) FY 1996, therefore, reflected some "catch up" adjustments and the FY 1997 amounts are more in line with historical trends.

In FY 1997, HRSA completed its draft strategic goals:

- Access and Systems Development: Promote the growth and integration of health care delivery systems to increase access for underserved, vulnerable and special need populations.
- Workforce: Promote a primary care and public health workforce that is qualified, diverse, culturally competent, and appropriately distributed to meet the needs of underserved, vulnerable, and special need populations.
- Quality of Care: Continuously improves quality of patient care, service delivery, workforce and outcomes in HRSA-supported programs.
- Managed Care: Assure that HRSA-supported delivery systems and workforce programs are effective participants in managed care, and that managed care policies are responsive to the needs of HRSA-supported populations.
- Monitoring, Analysis, and Outcomes Measurement: Provide leadership in measuring program performance, determining health outcomes and monitoring of health system changes in order to improve program effectiveness and better target resources.
- Management and Operations: Promote program accountability, efficiency, and cost effectiveness through improved management systems, and improve the quality of work life of HRSA employees.

In FY 1997, HRSA:

- Made grants totaling $802 million to support 685 community and migrant health centers, 128 health care for the homeless programs, and 22 health care programs for residents of public housing;
- Placed 2,298 physicians, nurses, dentists, and other primary care providers in underserved communities through the National Health Service Corps;
- Administered the $681 million Maternal and Child Health Block Grant to States to improve and expand the health care infrastructure serving pregnant women, mothers, infants, and children, and to serve children with special health care needs;
- Assisted States and eligible metropolitan areas meet the needs of people living with HIV/AIDS through $996.3 million for Comprehensive AIDS Resources Emergency (CARE) Act programs;
- Provided $289 million in scholarships, loans, and grants to health professions schools and their students to expand the diversity and improve the distribution of the health care workforce;
- Helped assure access to equality and quality of care for people in need of organ and tissue transplants, people with Hansen's Disease, and other rare diseases;
- Supported the National Practitioner Data Bank, which maintains records of physician and dentist malpractice and disciplinary action, and provides that information to hospitals and organizations that credential health care providers; and
- Administered the Vaccine Compensation Program for children who are harmed by routine immunization.



FOH nurses conduct examinations on-site at Federal workplaces.

HRSA Division of Federal Occupational Health: The HHS Franchise Fund Pilot

On January 24, 1997, the Director, OMB, officially designated HRSA's Division of Federal Occupational Health (FOH), as a Franchise Fund Pilot as provided for under GMRA following completion of the required Congressional consultation.

The FOH operates as a reimbursable service recovering all costs of operations through interagency agreements. The array of FOH services includes services to: (1) identify and correct environmental conditions within the workplace which can negatively affect employee health and productivity; (2) help employees maintain physical health and function safely in at-risk positions thereby maximizing the time on the job; and 3) help managers effectively resolve performance and conduct deficiencies through consultation and counseling designed to address both personal and workplace problems as well as broader development and training needs. The services are premised on the prevention of health problems and administrative support activities to keep employees on the job.

FOH is headquartered in Bethesda, MD with field offices throughout the country near concentrations of Federal employees. The locations of field offices and service delivery sites are flexible and are altered to meet Federal customer needs. FOH uses customer satisfaction surveys to elicit information about their services from the individual employee users of the service as well as from their supervisors when workplace issues are involved. This information is combined with feedback from Customer Advisory Boards comprised of Federal agency management representatives. FOH discusses their services with customer agencies and provides, and is developing, further performance based outcomes to ensure that the customer agencies' needs are met.

The Franchise Fund pilot programs support the Federal government's goal of seeking to procure administrative support services through full and open competitions designed to achieve best value/lowest cost to the taxpayer. To achieve this new level of accountability while seeking to provide the highest quality of services to their customers, franchises are encouraged to compete with other public offerors and the private sector on a level playing field, by considering the fully allocated costs (to the government/ taxpayer) for the same services. Competition with the private sector does not necessarily mean that when the public offeror is successful in a free and open competition that the private sector loses business opportunities. FOH is an example of a Federal entrepreneurial activity that uses a mix of federal and contractor personnel wherever and whenever it is cost-effective to do so. In FY 1997, approximately 87% of the FOH budget ($70.5 million out of $81 million) was expended for private services contracting and compensation for 1,200 contract occupational health professionals who comprise 90% of the FOH workforce.

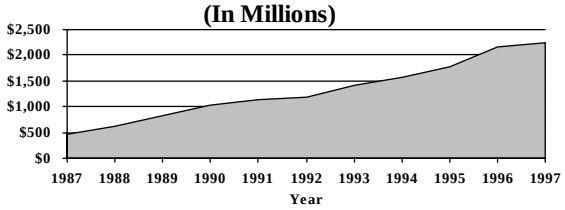
In FY 1997, FOH made fundamental changes in the mix of clinical services offered under its basic clinical agreements - so as to be able to offer a more competitive per capita rate. It also reduced federal employee FTEs, consolidated offices, instituted an organization-wide customer satisfaction program, and generally economized in the indirect cost area to offer lower prices for some product lines and to avoid raising them for others. Indirect costs themselves were cut 14% from '96 to '97. Although income dropped roughly $4 million, this was a planned drop in order to restructure the clinical services to be more cost-competitive in the future.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) AND AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

Founded in 1946, CDC is known as the "Nation's Prevention Agency" and for more than 50 years has provided leadership to public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities, and environmental health threats. The Comprehensive Environmental Compensation and Liability Act, legislation which established the Superfund, established ATSDR in 1980. ATSDR works to prevent exposures to hazardous wastes and environmental spills of hazardous substances. CDC's and ATSDR's efforts are appreciated when they respond to emergency situations (such as the deadly Ebola virus), but are most successful - and least noticed – when their prevention measures are effective.

The trendline for CDC's net outlays for the past decade indicates a relatively steady increase in funding. Most of CDC's revenue is derived from appropriations, though there is some revenue from the sale of goods and services to other governmental agencies and to the public. ATSDR receives its funding from the Environmental Protection Agency's (EPA's) Superfund program through an interagency agreement, and its outlays are included in the EPA budget. In this Accountability Report, CDC's financial statement summary also includes amounts for ATSDR. CDC/ATSDR's largest financial statement expense category is "grants, subsidies, and contributions," because so much of its work is carried out through grants to states, universities, and non-profit organizations.

Centers for Disease Control & Prevention
Net Outlays
(In Millions)



Collecting blood samples for Hepatitis prevalence study in Mexico

For the $2.2 billion (net) expended in 1997, some of CDC's accomplishments include:

- Exceeded ambitious goals set by the Childhood Immunization Initiative for vaccinations for diphtheria, tetanus, pertusis, polio, measles, Hib and hepatitus B. Only 308 cases of measles were reported, down from more than 27,000 cases at the peak of the measles resurgence in 1990. The number of 2-year olds immunized in the U.S. is at an all-time high for the most recent reporting period.
- Worked to control infectious disease threats, both emerging and reemerging.
- Focused efforts to prevent tobacco use, especially among teenagers.
- Continued to improve early detection and control systems for breast cancer and cervical cancer.
- Provided more than 1 million breast and cervical cancer screenings to low-income women through partnerships with the States, resulting in 2,918 women being diagnosed with breast cancer and 258 women being diagnosed with invasive cervical cancer.
- Sponsored a workshop to coordinate a multi-state response to public health issues about *Pfiesteria Piscicida*, an organism associated with recent fish kills on the U.S. eastern seaboard and which has been associated with human illness.

- Conducted studies of young adults exposed as children to high lead levels who performed poorly on neurologic tests and reported other adverse health effects, such as difficulty conceiving children.
- Found, in a study, significantly higher bone and blood lead levels in women formerly employed at Idaho's Bunker Hill lead smelter.
- Found, in a study, that infants born to tetrachloroethylene-exposed mothers who were 35 years or older were nearly four times more likely to be small for their gestational age.
- Found, in a study, that increased incidence of brain cancers in older women living near two sites that contained radioactive materials.
- Developed a means of measuring Cotinine (a by-product of tobacco smoke) in blood and demonstrated that this measurement reflects the amount of exposure to tobacco smoke in non-smokers.
- Took the lead in developing Personal Energy Plans (PEP), a step-by-step program designed to help employees integrate more physical activity and healthy eating into their life.
- Provided a national screening strategy for colorectal cancer. In FY 1997 about 131,200 new cases were diagnosed and 54,900 lives were lost to this disease.
- Provided infertility prevention services for over 800,000 women through a program established for early detection and treatment for women and their partners at risk for Chlamydia infection.
- Began implementing the National Occupational Research Agenda (NORA), which sets a framework for addressing gaps in occupational safety and health research and will result in safer, more healthful working conditions for America's workers.
- Collected information for over 7,000 foodborne illnesses under CDC's surveillance initiative.
- Launched the National Diabetes Education Program, in partnership with NIH, to improve the outcome of persons with diabetes, promote early diagnosis, and prevent the onset of this disease.
- Funded 50 diabetes control programs in 50 States, the District of Columbia, and 8 territories.
- Developed and tested a curriculum entitled, "HIV Prevention Counseling Issues for Women of Reproductive Age."
- Released "Respect Yourself, Protect Yourself," a public service announcement series targeting people aged 25 and under using $8 million of donated air time to prevent HIV infection among youth.
- Collaborated with national, regional and local groups representing young people to develop, implement and evaluate programs to change HIV risk behaviors.
- Improved the quality of laboratory practices; initiated development of a profile of laboratory tests and testing procedures including those for genetic testing in public health. Developed a model certification program for embryo laboratories.
- Responded to 95% of the epidemic outbreaks requested by States, localities and foreign countries.
- Reduced block grants application time by 80% through electronic implementation.
- Completed the Tuberculosis Information Management System (TIMS) in FY 1997, which replaced manual reporting by States.
- Published STD treatment guidelines in FY 1997. Guidelines are based on scientific evidence for the outcomes of STD therapy.

CDC worker takes soil sample.

Among its many accomplishments during FY 1997, ATSDR responded to a widespread, multi-state public health threat involving illegal use of the agricultural pesticide *methyl parathion.* Pesticide applicators, some of them unlicensed, sprayed homes and businesses, including day care centers, with methyl parathion, a pesticide legally restricted to outdoor agricultural use on non-food crops. Methyl parathion is chemically similar to some forms of nerve gas. People have reported symptoms of severe headaches, respiratory problems, vomiting, and diarrhea. Deaths have also been reported (*Morbidity and Mortality Weekly Report* 1984 33[42]:592-4). As of September 1997, approximately 5,800 premises had been reported sprayed with methyl parathion. Overall, approximately 18,000 people have been affected, including 10,000 children; 2,300 people have been relocated until their homes can be cleaned up. The states affected in FY 1997 were Mississippi, Alabama, Louisiana, Tennessee, Arkansas, Illinois, and Texas. State and local agencies requested federal assistance in handling the problem. ATSDR's response to that public health threat illustrates ATSDR's integrated approach to protecting public health. In general, the response included the following elements: health promotions, health education, risk communication, medical intervention, and capacity and partnership building.

Home and yard exposed to methyl parathion.

Child Health Initiative

Children are far more vulnerable than adults to the effects of harmful environmental toxins. They are shorter than adults, which means they breathe dust, soil, and heavy vapors close to the ground; they are also smaller, which means they get higher doses per body weight. Their developing body systems can sustain permanent damage if toxic exposures occur during critical growth stages. Most importantly, children depend completely on adults for risk management decisions, housing decisions, and access to medical care.

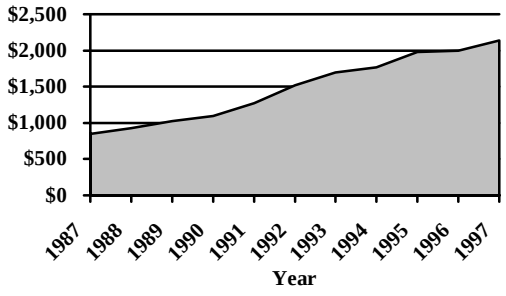
Approximately 1.3 million children under 6 years of age live within one mile of the borders of a site on the National Priorities List (NPL) of contaminated sites. This is a large number of young children at potential health risk. Children are not simply small adults! Children are clearly at greater risk from certain kinds of exposures to hazardous substances emitted from waste sites and emergency events. They are more likely to be exposed because they play vigorously outdoors (splashing, digging, and exploring) and they often bring food into contaminated areas.

ATSDR has concluded that these unique vulnerabilities of infants and children demand special emphasis in communities faced with contamination of their water, soil, air, or food. The Child Health Initiative adds that special emphasis to all of ATSDR's policies, programs, and activities. ATSDR hopes to mobilize outside interest in the broad fields of public health and environmental health and seeks to focus attention on human populations and their most vulnerable constituents. There is an equally compelling need to educate children and their parents, as well as child health providers and child health advocates, to prevent hazards to child health from site-related substances.

INDIAN HEALTH SERVICE (IHS)

IHS is responsible for providing Federal health services to American Indians and Alaska Natives. The provision of health services to federally recognized Indians grew out of a special relationship between the Federal Government and Indian tribes. This government-to-government relationship has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal Federal health care provider and health advocate for Indian people. Its mission, in partnership with American Indians and Alaska Natives, is to raise their physical, mental, social, and spiritual health to the highest level. The IHS provides health services to members of more than 550 federally recognized tribes in 35 states.

Indian Health Service
Net Outlays
(In Millions)



Contrary to entitlement programs, the IHS programs (like other Federal discretionary programs) are dependent on annual appropriations; therefore, health care services are based on funds availability, not on the actual level of need of American Indians and Alaskan Natives. Since FY 1992, the IHS has absorbed inflationary costs associated with the delivery of health care services.

Given the budget levels the IHS has experienced in recent years, balancing the goal of providing critical health care services while reducing administrative overhead and increasing tribal shares, will be a continuing challenge well into the next century.

During recent years, there has been a significant transition to tribal management of health programs under Title I and III of Self-Determination legislation. Currently, 42 percent of the IHS funding for services is under tribal control while significant proportions of Headquarters and Area administrative funding have been transferred to tribal programs.

This pattern, as well as the accompanying decentralization of many functions, has been more costly and has resulted in the fragmentation of programs (particularly for the public health infrastructure) in the short term. Still, in the long term, it is essential to the Self-Determination process, local ownership of health problems and capability development, and local program effectiveness.

In light of these trends and challenges, the IHS and its stakeholders have developed more alternative methods to assure efficient health programs and administrative support. For example, the reorganization and downsizing (50-70%) of the IHS Headquarters and many Area Offices was in response to not only budget constraints but also changing health care practices. The IHS now focuses on providing support to local Indian/Tribal/Urban programs (I/T/U) health programs and trying to maintain essential health care services even as overall IHS funding has diminished in real spending power.

With limited resources, efforts to meet the increasing demand for urgent care are affecting the availability of preventive services and impacting the public health infrastructure that supports community outreach and health promotion/disease prevention. Thus, a major challenge for the IHS is to find cost-effective strategies to maintain the public health focus. This focus has been a critical element to the achievement of significant improvement in the health status of the American Indian and Alaska Native people over the last 40 years. To this end, the IHS actively seeks partnerships with its stakeholders, other agencies, and organizations to collaborate in this critical effort.

GPRA is in direct correlation to the budget process. IHS welcomed GPRA as an extension of the public health planning model that the IHS has used for many years. Beginning with the FY 1998 budget submission, the IHS included performance indicators for two programs (dental and diabetes) as GPRA pilot projects. Outcome results will be reported in the Accountability Report for FY 1998.

With this broad guidance, IHS integrated the formulation of the FY 1999 initial budget request with the development of the FY 1999 GPRA annual performance plan for stakeholders through workshops held in February and March of 1997 in all twelve areas. In these workshops, stakeholders learned of the Agency's new decentralized approach to obtain a new level of tribal participation in the budget formulation process and its link to the GPRA implementation.

The submission of each Area's GPRA recommendations and initial budget request identified a relatively high level of agreement on the most significant health problems and funding priorities. Finally, through a series of consultations with tribal organizations, I/T/U staff, epidemiologists, and program staff, the plan evolved to its present form.

The IHS 1999 Annual Performance Plan consists of 25 performance indicators that incorporate health-related process, impact, and outcome measures. The plan has received support from the IHS stakeholders.

DIRECTOR'S INITIATIVES

The IHS Director has identified the following as major health initiatives and emphasis areas, noted here with related FY 1997 accomplishments:

Women's Health

- Awarded $800,000 in grants to tribal and urban Indian programs and non-profit Indian organizations for Indian Women's Health Demonstration Programs to increase services, improve data collection, and encourage research for American Indian and Alaska Native women.
- Expanded the IHS epidemiological surveillance of women's health status and identified specific preventable diseases with regional variations that required tailored outreach to diagnose women earlier with breast and cervical cancer.
- Increased the number of female providers in response to the cultural needs expressed by Indian women. This contributed to an increased number of women seeking health maintenance and disease prevention services.
- 15 program grants with CDC were awarded for early detection of breast and cervical cancer country-wide.
- Two Indian health care facilities were awarded grants for breast/cervical cancer screening from the PHS Office of Women's Health.

Children/Youth Initiative

- IHS proposed a multi-agency initiative for American Indian and Alaska Native youth and adolescents around two themes: (1) *Ensuring a safe and healthy home and community,* and (2) *Ensuring personal development within the context of developing communities.* Response has been encouraging with active participation from Housing and Urban Development, Department of the Interior, Department of Agriculture, Department of Transportation, and several HHS agencies.
- A proposed Executive Order that all agencies with programs and activities related to children and youth also focus on American Indian and Alaska Native children and youth as a priority.
- Awarded $900,000 in 5-year grants to tribal communities for child abuse prevention and treatment.

Injury Prevention

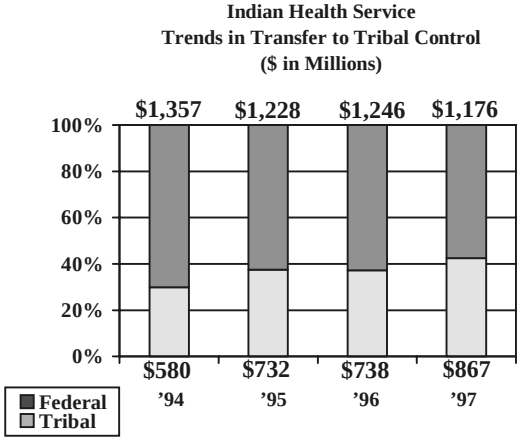
- Awarded thirteen grants for a total of $304,000 for Tribal Injury Prevention Infrastructure program. Provided funding for part-time and full-time injury prevention practitioners with local Tribal Health Authorities. These practitioners gather data, build coalitions of concerned people (i.e., law enforcement, tribal leaders, and lay people), and develop plans of action for community based projects.
- Funded a $30,000 feasibility study with the United Tribes Technical College to develop a curriculum in Injury Prevention.
- Trained 200-250 people nation-wide as injury prevention practitioners for community based injury prevention programs.

Elder Health

- Initiated a grant program for tribes and tribal organizations to develop demonstration programs for elder services. Seven grants totaling $800,000 were awarded.
- Provided consultation and education on geriatric assessment and treatment for nursing staff at a major nursing conference.
- Provided consultation and education of geriatric pain management to physicians in the Billings Area.

TRIBAL SELF DETERMINATION

Tribes can administer IHS Federal health services and programs through tribal contracts and compacts or elect to continue to receive those services directly from the IHS. Based on requirements described in the amendments of Public Law 93-638, the Indian Self-Determination Act, tribes administer the programs and funds as well as submit annual financial audits. Through compacts and contracts, tribal governments provide health services to a third of the American Indians and Alaska Natives and administer forty-two percent of the IHS resources.

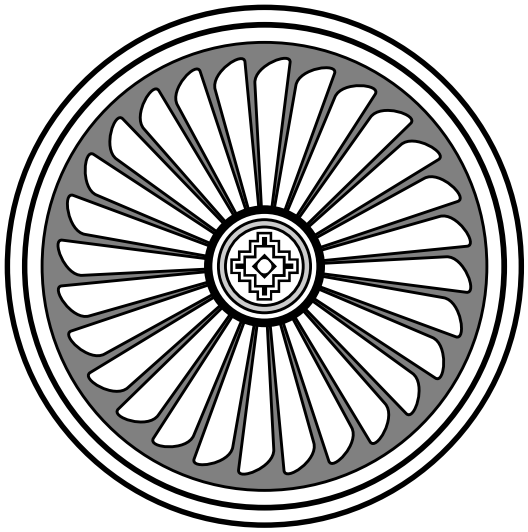


Title I Contracts

- *Publication of IHS Tribal Consultation and Participation Policy, IHS Circular 97-07.* It is available as a resource and model for other HHS agencies.
- *Report to Congress, Contract Support Cost Funding in Indian Self-Determination Contracts and Compacts.* Provided supporting documentation through extensive data analysis that the escalation of tribal indirect costs was reasonable.
- *Development of Self-Determination Internal Agency Procedures Manual.* A manual to implement the 1994 Amendments (P.L. 103-417) to the Indian Self-Determination Act and its Final Rule. The IHS, the Bureau of Indian Affairs, and representatives of tribal governments is developing this manual. The final manual is scheduled for adoption by the Federal agencies in Spring 1998.
- Approved and awarded thirty-four grants in the Tribal Management Grant Program. These grants support a variety of purposes such as strengthening weaknesses in tribal management systems and developing effective health strategies for tribal governments.

Title III Compacts

- Negotiated and signed 34 compacts and 48 Annual Funding Agreements (AFA) representing 238 tribes for $350 million in FY 1997.
- Through the flexibility and redesign provisions of the Self-Governance Demonstration Project, tribes have been successful in:
  (a) Improving and expanding the quality and quantity of services to their elderly population.
  (b) Improving and expanding their dental and visual care programs.
  (c) Development of special diabetes treatment programs with staff specially trained in the treatment of diabetes.
- The Jamestown S'Klallam Tribe developed an insurance-based managed care program.
- The Joint Tribal/IHS Baseline Measures Workgroup report was completed which addresses reporting requirements and performance measures for tribal programs implemented under Self Governance.

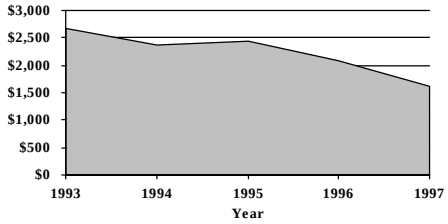


SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMSHA)

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.

Although SAMHSA's funding for programs was dramatically decreased in FY 1996, funding was restored almost to prior year levels by Congress in FY 1997. Increases in budget authority for 1997 will be evidenced by increases in outlays in 1998. Funding for SAMHSA's formula grant programs has been fairly stable from 1995 to 1997, with a $11.6 million decrease in budget authority from 1995 to 1996 and a $128.1 million increase in budget authority from 1996 to 1997. Funding for the discretionary programs reflect a net decrease in overall funding during the same period including a $292.9 million decrease from FYs 1995 to 1996, offset by a $172.7 million increase from 1996 to 1997.

Substance Abuse and Mental Health Services Administration Net Outlays (In Millions)



SAMHSA operates three centers: the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. In addition, six special offices have been created to focus and coordinate the Agency's work in certain areas: the Office of Applied Studies; the Office of Managed Care; the Office on AIDS; the Office for Women's Services; the Associate Administrator for Alcohol Prevention and Treatment Policy; and the Associate Administrator for Minority Health Concerns. The Office of Program Services (OPS) and the Office of Extramural Activities Review (OEAR) support the above mentioned Centers/Offices.

SAMHSA's funds are channeled through Federal grants and contracts to States and local agencies and to private service providers in order to improve the effectiveness of existing prevention and treatment services, expand and maintain service capacity, as well as measure outcomes and promote program accountability.

SAMHSA's FY 1997 accomplishments include the following:

- The **Access to Community Care and Effective Services and Supports (ACCESS) Cooperative Agreement Demonstration Program** is a five-year interdepartmental effort to test the impact of systems integration on outcomes for homeless people with mental illnesses.

  · After three months of services, consumers enrolled in ACCESS reported a 47% reduction in the number of days literally homeless and a 76% reduction after 12 months. Correspondingly, the number of days housed had increased dramatically.

  · After 3 months, 24% of the consumers were living in stable independent housing, and 43% after 12 months.

  · After 12 months of services, the first three cohorts of ACCESS consumers showed the following specific improvements:
  - 54% *decrease* in minor criminal activity;
  - 44% *decrease* in consumers reporting victimization by others;
  - 34% *decrease* in total days of drug use;
  - 35% *decrease* in reported psychotic symptoms;
  - 43% *decrease* in reported depressive symptoms; and
  - 33% *increase* in the number of days worked.

- Finally, consumers in integrated systems are shown to have better housing outcomes than those in less integrated systems.

- Initiated the **Community Action Grants for Service Systems Change** project to promote the adoption of exemplary mental health service practices.

- The **Children's Mental Health Initiative** supported communities across the country in development of culturally competent, community-based, interagency approaches to serving children and adolescents with serious emotional disturbances, and was recently recognized with the National Performance Review Hammer Award.

- Worked with States in pilot testing the Partnership for Planning and Performance, which will enhance the management and reporting capacity of States and will serve as a basis for comparable performance indicators among State mental health systems.

- **Starting Early Starting Smart (SESS)**, a child-centered, family-focused, and community-based cross center initiative that represents a collaboration with other HHS agencies, the Department of Education, and The Casey Family Program, awarded $6.1 million to support 13 grants.

- SAMHSA awarded five State Incentive Grants for a total of $15 million, to initiate the Secretary's **Youth Substance Abuse Prevention Initiative (YSAPI)**. These grants call upon State Governors to develop comprehensive strategies for youth substance abuse prevention in their State. SAMHSA also awarded 5 grants totaling $5 million to regional centers for the application for prevention technology to support States and communities.

- **Girl Power!** Media campaign has grown into a national, HHS-sponsored campaign that also empowers girls to focus on such issues as physical activity, nutrition, and mental health and has been endorsed by over 300 organizations and agencies.

Information on substance abuse and HIV/AIDS prevention is provided to community resident.

- **Reality Check** campaign raises awareness of the dangers of marijuana use, distributing 5,000 community kits, a magazine for youth aged 12 to 17 and public service announcements.

- Currently all states are in compliance with the **Synar Amendment**. Every State has in place a law prohibiting the sale or distribution of tobacco products to minors.

- SAMHSA conducted 4 regional work sessions with all 50 States on the implementation of welfare reform in 1997. The **Welfare to Work** grant program has relevance in that millions of welfare recipients can be potentially favorably impacted by the establishment of substance abuse treatment services as part of the welfare reform initiative.

- SAMHSA successfully planned for and negotiated the transfer of the Federal monitoring and oversight functions for **pharmacotherapy in opioid addiction treatment** from the Food and Drug Administration. This accreditation/regulatory model will benefit the treatment field by shifting from a purely regulatory program to one that provides for accreditation from licensed independent bodies.

Substance Abuse Treatment Does Work

The 1996 National Treatment Improvement Evaluation Study (NTIES) shows that decreases in drug use are sustained an average of 50% of clients, one year following treatment. Arrests for any crime decreased 64%. Results from this study also show post treatment declines in high risk sexual behaviors, homelessness, medical visits related to drug and alcohol abuse, and inpatient mental health visits. At the same time, an increase in employment is seen.

The following are examples of NTIES findings on treatment effectiveness:

- 78 percent reduction in the percentage of individuals engaging in both the sale of illicit drugs and violent crimes;
- 19 percent increase in the rate of employment;
- 42 percent decrease in the percentage of individuals who were homeless;
- 53 percent decrease in alcohol and other drug-related medical visits;
- 28 percent decrease in inpatient mental health visits; and
- 34-56 percent decrease in "high risk" sexual behaviors associated with the transmission of HIV.

The Drug Abuse Treatment Outcome Study had similar results. Among participants in outpatient methadone treatment, heroin use decreased 70 percent, cocaine use decreased 48 percent (these are polydrug users), illegal activity decreased 57 percent, and full time work increased by 24 percent.

Another recently completed SAMHSA study of treatment interventions for Job Corps participants (1996) shows that adolescents who receive enhanced treatment services (compared with those who did not): (1) are less likely to use drugs and get involved with drug trafficking during and after treatment; (2) show increases mental health functioning and emotional well being; (3) show increased educational success and job placement; and (4) are less likely to receive public assistance after treatment.

How Big is the Mental Health Problem in America?

Each year, approximately 44 million American adults experience some form of mental disorder and an estimated 10 million of these individuals experience symptoms of such severity and duration that they are considered to have a serious mental illness. In addition, an estimated 3.5 to 4 million children and adolescents between the ages of 9-17 in the United States have a serious emotional disturbance during any one year. The total number of children with serious emotional disturbance is estimated to be significantly higher, however, currently there are not sufficient studies to determine the prevalence rate in very young children ages birth to age eight.

FOOD AND DRUG ADMINISTRATION (FDA)

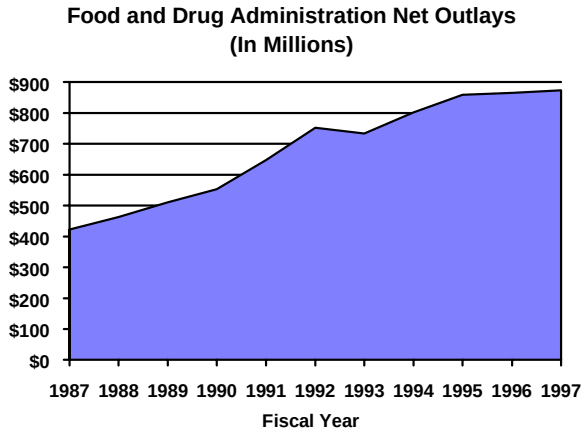
FDA is one of our nation's oldest consumer protection agencies. It is a scientific regulatory agency mandated to protect and promote the health and well-being of consumers in the United States. In carrying out this mandate, FDA's approximately 9,000 employees monitor the manufacture, import, transport, storage, and sale of $1 trillion worth of products year.

FDA's responsibilities include ensuring that: (1) food is safe, wholesome, and free from adulteration; (2) human and animal drugs, biological products (vaccines and blood products), and medical devices are safe and effective; (3) radiological products are safe and do not expose people to unnecessary radiation; (4) cosmetics are safe and unadulterated; and (5) all the above-mentioned products are honestly and informatively labeled (in the case of drugs, this includes information on possible side effects).

Out on the docks and in the airports, FDA inspectors look for signs of filth, spoilage, contamination, or mislabeling of foods.

> ***"Hard-working American parents deserve the peace of mind that comes from knowing that the meal they set before their children is safe."***
>
> **President Bill Clinton**
> **January 25, 1997 Radio Address**

As can be seen in the 10-year trendline, FDA's net outlays were increasing at a more rapid pace during some years in the late 1980's and in FYs 1994 and 1995. This is attributable to increased funding targeted towards expediting reviews of applications for generic drugs and AIDS-related products (see below), food safety inspections, the passage of the Safe Medical Devices Act, construction of new facilities, and efforts to eliminate the backlog of overdue new drug applications during those periods. FY 1997 net outlays rose slightly over FY 1996.



In FY 1997, FDA:

- Approved an implant device to control incontinence,
- Approved a simple, more accessible lead poisoning test kit,
- Announced a strategy to improve safety of fruit juices,
- Approved a new hand implant for quadriplegics,
- Issued final rules on labeling for nutritional supplements,
- Approved a medical device for epilepsy, and
- Launched a Prescription Information Program.

The following table shows significant improvement in FDA's "on time" reviews for FY 1994 through 1996 cohorts. Cohorts are defined as the group of submissions filed with FDA during a particular fiscal year. "On time" is defined as 12 months for new drug applications and efficacy supplements, and six months for resubmissions and manufacturing supplements.

Also in 1997, FDA made significant progress in streamlining operations to improve consumer access to drug information, cut red tape, and speed approval of new medical products and devices. At the end of 1997, the agency has cut new drug approval times nearly in half, while the number of new drugs approved in a year has doubled. In recognition of its innovations of the U.S. drug approval process, the FDA was named a 1997 winner of the prestigious Innovations in American Government Awards Program, sponsored by the Ford Foundation and Harvard University's John F. Kennedy School of Government.

Percent of "On Time" Reviews
For FY Cohorts
As of 12/1/97

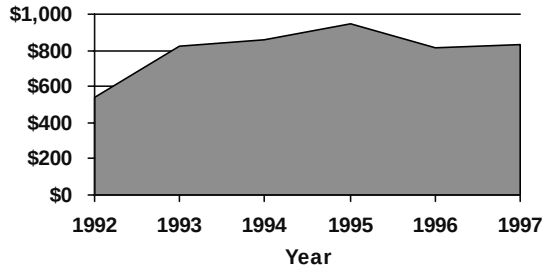
Type of Submission	1994	1995	1996
New Drug Applications	95	98	96
Resubmissions	83	97	99
Efficacy Supplements	77	95	96
Manufacturing Supplements	66	90	96

ADMINISTRATION ON AGING (AoA)

AoA serves older individuals and their caregivers through the provision of grants and dissemination of information to States, Tribes, tribal organizations, and other entities. AoA works through a nationwide network of regional offices, State and Area Agencies on Aging, and tribal organizations to plan, coordinate, and develop community-level service systems. The small staff of AoA (131 Full Time Equivalents), reduced by more than 30 percent over the last several years, is responsible for overseeing the vast network of 57 State units, 222 Indian tribal organizations serving more than 300 tribes, 655 area agencies on aging and more than 27,000 service providers throughout the country.

The trendline for AoA's net outlays reveals a slight increase in net outlays in FY 1997 compared to FY 1996. This is because funding for AoA's programs (including formula grants) increased $10 million or 1.2% in 1997.

Administration on Aging Net Outlays (In Millions)



AoA activities include funding for the following activities:

- Nutrition services, which provide over 240 million congregate and home-delivered meals annually, celebrated its 25th anniversary in 1997. A major evaluation two years ago found this to be one of the most efficient and effective of Federal programs. It is targeted to those most in need: about half of meal recipients are low-income elders and over 25 percent are members of minority groups. Nutrition services are the core of a comprehensive and coordinated system of community-based services.
- Supportive services, which include transportation — over 40 million rides for doctor and pharmacy visits, nutrition and related activities; over 12 million responses for information and assistance and access to vital services for seniors and their families; nearly ten million personal care services to elderly in need; and about one million legal counseling sessions.
- In-home services for the frail elderly, which include an additional 1.3 million personal care services and 700,000 reassuring visits and telephone calls.
- Protection of vulnerable older Americans, which includes State long-term care ombudsman programs, prevention of elder abuse, State elder rights and legal assistance programs, and outreach, counseling and assistance. These programs are central to the advocacy role mandated by the Older Americans Act.
- Aging Training, Research and Discretionary Programs, to provide critical support for a number of activities, including AoA's national toll-free Eldercare Locator and resource centers for older Indian, Alaskan Natives and Native Hawaiians. This Title has also been the means by which we provide critical disaster assistance to older persons traumatized by Presidentially-declared natural disasters.

- Essential support for Operation Restore Trust (ORT), a very successful demonstration project to combat Medicare fraud, abuse and waste, launched by President Clinton in 1995, which is expanding nationally. Together with HCFA, the HHS Office of the Inspector General (OIG) and the Department of Justice, AoA reaches out to thousands of older persons by recruiting and training local ombudsmen, aging service providers, volunteers and retired professionals to identify and report waste, fraud and abuse in their own states and communities.

In 1997 AoA:

- Announced three new grants for statewide legal hotlines in Georgia, Iowa, and Washington. Funding was continued for other hotlines (Hawaii, Kansas, Maine, Michigan, and Mississippi) to assist older Americans who might have difficulty navigating the legal system.
- Signed a Memorandum of Understanding (MOU) with EPA and others designed to tap into the networks of aging and senior volunteers to help protect America's environment.
- Developed a successful public/private partnership with General Mills to expand meal service to include breakfast meals for seniors, resulting in twenty "Morning Meals on Wheels" pilot projects.
- Began operating the National Aging Information Center (NAIC) as a part of the Administration on Aging. NAIC is a central federal source for a wide variety of program and policy related materials, demographic, and other statistical data on the health, economic and social status of older Americans. This center had previously operated under contract.
- Greatly increased the availability of information for older persons and their families on caring for older family members and obtaining needed services through the expansion of the AoA web site (www.aoa.dhhs.gov). Usage increased by over 100% during 1997.
- Began funding Health Care Fraud and Abuse Prevention efforts through grants to States, Area Agencies on Aging, and other non-profit agencies to train older persons in recognizing Medicare Fraud.
- Continued a thorough organizational development process including meetings with stakeholders and agency staff to redesign agency processes and systems.
- Successfully developed AoA's initial performance plan and associated performance measures through a collaborative process involving agency staff, federal, State, and local partners. Performance measurement will rely on information supplied by State Aging Agencies through the National Aging Program Information System (NAPIS).

AoA's programs benefit America's senior citizens.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR)

AHCPR's mission is to generate and disseminate information that improves the delivery of health care. AHCPR is the primary Federal agency charged with determining what works best in clinical practice, improving the cost-effective use of health care resources, helping consumers make more informed choices, and measuring and improving the quality of care. AHCPR revenues are derived from appropriations (67 percent of revenues) and reimbursables (33 percent). AHCPR had 257 FTEs in FY 1997, employing experts in health policy, epidemiology, sociology, and statistics. It accomplishes its mission largely through the awarding of grants, contracts and interagency agreements, which account for 78 percent of total FY 1997 expenses.

AHCPR has three major programs:

- *Research on Health Care Systems, Cost, and Access (HCSCA*), which focuses on studies of immediate and long term importance to policy makers, health care professionals and the public and analyzes how Americans use and pay for health care,
- *Research on Health Care Outcomes and Quality (HCOQ*), which aims to determine what works best in medical care, and
- *Medical Expenditure Panel Survey (MEPS)*, an interrelated series of surveys that serve as the national source of information for estimating the costs, analyzing financing options, and determining possible consequences of potential changes to the U.S. healthcare system.

In FY 1997, AHCPR awarded ten new investigator-initiated grants on a variety of topics including:

- Effects of Medical Malpractice Reform,
- Respiratory Illness in Infants,
- Efficacy of Telemedicine Colposcopy,
- Statistical Inference and Cost-Effectiveness Analysis,
- Patient-Centered, Computer Assisted Quality Improvement,
- Impact of Guidelines on Quality of Care: Unstable Angina,
- Quality Well-Being (QWB) Scale Revision Project,
- Optimal Timing of Liver Transplantation,
- Market Power and Efficiency Effects in Hospital Mergers, and
- Medical Intervention of Effectiveness and Effectiveness and Outcomes.

Health Facts

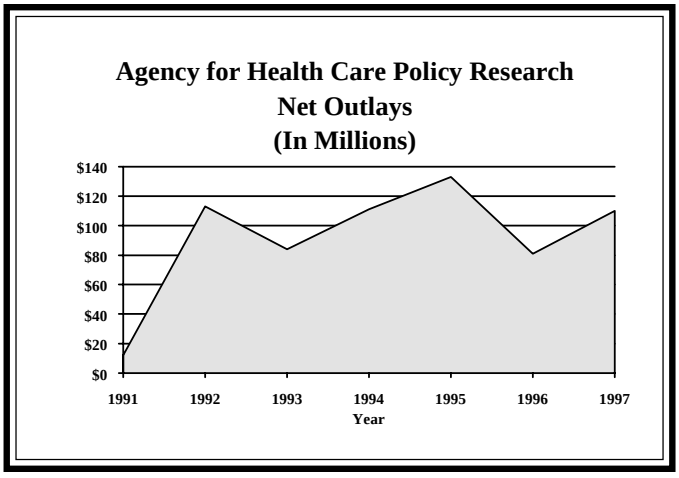
- Seventeen percent of the U.S. population were uninsured through the first half of 1996.
- Almost 53 percent of children covered by Medicaid have at least one working parent.
- Less than half (41.3 percent) of young adult workers aged 19-24 were offered health insurance by their employers.
- Almost 66 percent of U.S. nursing homes in 1996 were operated for-profit.
- Over 80 percent of nursing home residents needed help with 3 or more daily living activities.
- Almost half of all nursing home residents have some form of dementia.

Source: Medical Expenditure Panel Survey (MEPS)

Also in FY 1997, the results of grants awarded in previous years delivered the following results and/or information:

- The use of antibiotic erythromycin for treating community-acquired pneumonia (CAP) in most outpatients aged 60 and under, reduces treatment costs compared with the use of other antibiotics ($5.43 vs. $18.51), and has no adverse effects on medical outcomes.
- Emergency Diagnostic and Treatment Units (EDTUs) offer an alternative to inpatient hospitalization for adults suffering from reversible diseases such as acute asthma. More than half of the asthma patients now admitted to the hospital could be treated just as effectively, at about half the cost.
- Patients suffering from chest pain can avoid a costly hospital admission and be treated just as effectively when accelerated diagnostic protocols are used in an observational unit of an Emergency Department.
- A computerized decision-making aid built into an EKG machine instantly prints predictions of whether that individual will benefit from potentially lifesaving treatment with thrombolytic (clot dissolving) drugs.
- Errors in administering drugs may account for up to 140,000 deaths annually, increases length of stay by 2 days, and result in death in 0.3 percent of hospital patients. Up to 70 percent of adverse drug events are preventable by health care interventions such as system-wide quality improvement and patient or physician education.

AHCPR's net outlays reflect a series of peaks and valleys between FY 1991 - FY 1997. This is due to the volatile change in the mix of AHCPR's funding sources, which include budget authority funds as well as offsetting collections, from year to year. Because net outlay amounts are calculated by deducting offsetting collections from disbursements, the "peaks" and "valleys" are driven by the amount of offsetting collections appropriated to AHCPR.



PROGRAM SUPPORT CENTER (PSC)

PSC was created in FY 1996 to be a self-supporting OPDIV at the HHS. As the first true business enterprise at HHS, PSC provides services on a competitive, service-for-fee basis to customers throughout HHS. In addition to HHS offices and agencies, PSC customers include at least 25 other executive departments and independent Federal agencies.

The formation of the PSC was a direct result of the REGO II initiative, which reviewed the organization, financing, and governance of the Department's common-use administrative services. The REGO II analysis determined that the most efficient method of organizing the Department's administrative service providers is a single organization dedicated to the provision of cost effective, quality services.

The activities and services of the PSC are supported through the HHS Service and Supply Fund (a revolving fund) which was established by 42 USC 231. The Fund provides consolidated financing and accounting for business-type operations involving the provision of common services and commodities to customers. It is governed by a Board of Directors chaired by the Deputy Secretary with the Assistant Secretary for Management and Budget (ASMB) serving as Vice-Chair. The Board includes representatives from each HHS Operating Division (OPDIV), the chief business managers of the PSC, and the Inspector General, ex officio.

Each PSC Service is managed in such a way as to be self-sustaining and in FY 1998 all will be operating on a 100 percent service-for-fee basis. The expenses of each activity are billed to the customers based upon actual consumption of services or products. Services are provided in three broad business areas: human resources, financial management, and administrative operations.

PSC net outlays for FY 1997 include the following activities:

	Net Outlays (In Millions)
Results From Operations of the PSC (Excess of Revenues over Expenses)	$ (5)
Retirement Pay and Medical Benefits for PHS Commissioned Officers	180
Miscellaneous Trust Funds	49
	$ 224

Human Resources Service

The Human Resources Service (HRS) provides leadership in personnel administration for the PSC, as well as directly providing personnel and payroll services to HHS and other Federal agencies. The HRS provides a complete package of human resource services. These services include automated personnel and payroll systems support, personnel and payroll processing, staffing and classification, employee and labor relations, training and career development, and Commissioned Officer personnel support in some form to all components of the Department including the PSC and other customer agencies.

Financial Management Service

The Financial Management Service (FMS) supports the financial operations of HHS and other Departments through the provision of payment management services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates. These rates include indirect cost rates, research patient care rates, and fringe benefit rates. The FMS also provides specialized Automated Data Processing (ADP) systems development in the area of workforce management.

Administrative Operations Service

The Administrative Operations Service (AOS) provides a wide array of administrative management services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government. The major areas of service are property and materiel management, and support services ranging from commercial graphics to mail distribution and telecommunications services. The Telecommunications Improvement Project consolidates telephone services under one contract with substantial savings in telephone bills to agencies in the Parklawn complex, NIH campus, and the FDA complex in Beltsville, Maryland. The AOS also operates a medical supply depot, the Supply Service Center, located in Perry Point, Maryland, that provides services and supplies to over 1,700 customers on a worldwide basis and is an economical source of supply for all Federal customers.

PSC's FY 1997 accomplishments included the following:

- A strategic plan was developed for the PSC which served as a guide for the Service Business Plans. This plan focuses on two main goals: improve cost competitiveness and quality of services to meet our current customer needs and attract new customers.
- PSC achieved full cost recovery on a service-for-fee basis.
- Performance plans have been developed under the Government Performance Results Act of 1993.
- PSC provided timely contract awards and payments for the DC Government.

Human Resources Service

- Physical move and consolidation of most HRS personnel to Silver Spring which resulted in a $2 million savings.
- FED HR-21, the new personnel and payroll modernization effort, is being implemented.
- Negotiated 34 interagency agreements amounting to over $2 million which resulted in reduced rates for customers.
- Consolidated employee and labor relations staff at headquarters saving FTEs.
- Vigorously marketed FED HR-21 and currently negotiating with Federal components for over 50,000 new pay accounts.
- In partnership with OS, opened a Work Family Center which will serve as a model for the entire government.

Financial Management Service

- Completed 1,820 rate negotiations resulting in cost avoidances of $540 million and program disallowances of $28 million.
- Negotiated first major shift in cognizance assignment of colleges and universities in 25 years.
- Settled civil lawsuit and negotiated indirect costs with New York University Medical Center with largest payment ($15 million) by a university for over-recovery of indirect costs.
- Implemented 100 percent EFT for travel payments.

- Processed 728,000 commercial payments with an on time rate of 96.8 percent.
- Received designation as the HHS Debt Collection Center increasing customer base to include HCFA, CDC, and NIH.
- Processed 300,967 grant payments to 16,000 recipients for a total of $186 billion.
- Resolved 335 audits and collected $325 million in refunds, interest, and audit disallowances.
- Added 1,948 new recipient accounts to the Payment Management System.
- Recipient customer satisfaction survey reported 95 percent "satisfied" or "very satisfied" with the Division of Payment Management.

Administrative Operations Service

- Totally revised rate structure for new contracts and contract modifications reducing costs to customers.
- Defined the role of the Regional Operations staffs and received S&SF Board of Directors approval.
- Expanded telecommunications Improvement Project to six new locations with over 1,000 additional lines.
- Implemented a Computer Ordering and Information Network (COIN) at the Supply Service Center utilizing its inventory network and Internet technology.
- Obtained a minimum $45 million order from the Veterans Administration for the Supply Service Center and received Board approval to add a second shift to support this increased business.

OFFICE OF THE SECRETARY (OS)

The Office of the Secretary (OS) is the organizational unit responsible for coordination of policies and activities of all operating divisions at HHS. The Secretary serves as the President's key advisor on issues dealing with health care policy, health research, and human services issues. The Secretary is often able to call upon several parts of the HHS to create a synergistic response to a national problem or issue. For example, the campaign to fight teenage smoking involves FDA, CDC, and ACF.

The **Immediate Office of the Secretary (IOS)** provides leadership, direction, policy, and management guidance to the Department, and support for the Secretary and Deputy Secretary in their roles as representatives of both the Administration and HHS. IOS serves as the nucleus for HHS activities, providing staff support essential for the Secretary to manage and direct the myriad programs mandated to the Department. Responsibilities associated with policies and issues that the Secretary and HHS must confront daily include more than 300 programs, covering a wide spectrum of activities. Some of these issues include improving healthcare quality, biomedical research, food and drug safety, reduction in the use of tobacco products, Medicare, Medicaid, HIV/AIDS, women's health, public health, Head Start, teen pregnancy, youth substance abuse as well as many other critical Federal responsibilities.

The **Office of the Assistant Secretary for Public Affairs (ASPA)** serves as the principal public affairs officer in all aspects of Departmental policy and activities; oversees the planning, management and execution of communication activities throughout HHS; conducts Departmentwide public affairs programs; provides public information and support on legislative initiatives which cut across program and OPDIV lines within the Department; establishes and administers the Freedom of Information Act (FOIA) and Privacy Act Departmentwide; and provides information on Departmental actions and purposes to the general public.

The **Office of the Assistant Secretary for Legislation (ASL)** serves as the principal advocate before Congress for the Administration's health and human services initiatives, serves as chief HHS legislative liaison and principal advisor to the Secretary and the Department on Congressional activities, and maintains communications with executive officials of the White House, OMB, other Executive Branch Departments, members of Congress and their staffs, non-governmental organizations and associations, and selected legislative programs. ASL's responsibilities include advising the Secretary on all policy matters relating to HHS legislation; serving as an information resource for members of Congress and staff on HHS programs, grants and initiatives; providing guidance on the development and analysis of Departmental legislation and policy, including formulation of the budget; directing and coordinating legislative initiatives to ensure consistent and strong advocacy before Congress; and securing Congressional enactment of program and policy reform proposals.

The **Office of the Assistant Secretary for Planning and Evaluation (ASPE)** provides policy analysis and advice; guides the formulation of legislation; coordinates strategic and implementation planning; conducts regulatory analysis and reviews regulations; oversees the planning of evaluation, non-biomedical research, and major statistical activities; and administers evaluation, data collection, and research projects that provide information needed for HHS policy development. These functions can be grouped into two components: planning and policy analysis and development, and policy management and support. Most ASPE resources are used for policy analysis and development; the remainder is used to provide policy support in the form of executive direction, administration, planning and monitoring of activities to achieve the Department's goals and objectives, oversight of evaluation, coordination of departmental data policy, and services, including simulation modeling, programming, and technical assistance.

The **Office of Intergovernmental Affairs (IGA)** is composed of a headquarters office and the ten offices of the Regional Directors (RDs). IGA undertakes a variety of assignments for the Secretary, the Deputy Secretary, and the Director of Intergovernmental Affairs in the areas of administration, management, and intergovernmental affairs. IGA also works closely with national intergovernmental interest groups and with individual state and local officials, ensuring that important lines of communication are maintained between all levels of government. The RD also supervises the Regional Health Administrator. The RDs coordinate a range of outreach activities and facilitate cross-cutting initiatives in the field. The RDs develop close relationships with governors, mayors, county officials, and other elected and appointed officials; they also track HHS region-specific, Federal and State legislative actions. Finally, the RDs serve as surrogate speakers for the Secretary, and inform the media and public of program initiatives of the Administration and the Department.

The **Office for Civil Rights (OCR)** is responsible for enforcing civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes cover nondiscrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion. In addition, OCR coordinates implementation of the Section 504 regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS. OCR enforces nondiscrimination requirements by processing and resolving discrimination complaints, conducting reviews and investigations, monitoring corrective action plans, and carrying out voluntary compliance, outreach and technical assistance activities. Each of OCR's compliance activities ensures that individuals are treated in a nondiscriminatory manner by health and human services provider agencies or facilities. OCR's work protects individual rights and simultaneously supports HHS goals for improving the health and well-being of individuals, families and communities.

The **Office of the General Counsel (OGC)** oversees the provision of legal advice and representation to all components of the Department, on all aspects of agency operations. Specific legal services provided by OGC to the Department include: representation in both administrative and judicial litigation; preparation of legal opinions; drafting and legal review of legislation, regulations, contracts and other documents; and provision of informal legal counsel.

The **Assistant Secretary for Health (ASH)** in the **Office of Public Heath and Science (OPHS)** is the Secretary's principal advisor for public health and science and provides senior professional leadership in the Department on public health and science. The ASH and the Surgeon General assure through leadership and advice that HHS conducts broad-based public health assessments designed to better define public health problems and to design solutions to those problems, including solutions aimed at eliminating health disparities between racial and ethnic groups; anticipating future public health issues and problems in partnership with other HHS components; and ensuring that HHS designs and implements appropriate approaches, interventions, and evaluations to maintain, sustain, and improve the health of the Nation. Maintained within OPHS are several other offices including those for HIV/AIDS Policy, Disease Prevention and Health Promotion, Minority Health, Women's Health, the President's Council on Physical Fitness and Sports, and others.

The **Assistant Secretary for Management and Budget (ASMB)** also serves as the Chief Financial Officer (CFO) and the Chief Information Officer (CIO). The ASMB is responsible for the preparation of this ***Accountability Report***. ASMB functions are discussed in detail in other sections of this report.

The mission of the **Office of Inspector General (OIG)** is to improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits (including the Departmentwide financial statement audit – See Section VI), evaluations, and investigations, the OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.